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Dr. William D. Sawyer (5) interview conducted on February 20, 1985 about the Boonshoft School of Medicine at Wright State University

William D. Sawyer

James St. Peter

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WRIGHT STATE UNIVERSITY
School of Medicine Oral History Project

Interview date: February 20, 1985

Interviewer: James St. Peter

Interviewee: William D. Sawyer, M.D.
Second Dean, WSU School of Medicine
Interview 5

JSP	<p>My name is James St. Peter and this is the fifth in a series of interviews with Dr. William D. Sawyer, current dean of the Wright State University School of Medicine. The date is February 20, 1985. The time is 9:00 AM and Dean Sawyer and I are in Room 115C of the Medical Sciences Building here at Wright State University. Dean Sawyer in our last interview we talked about some of the things that happened immediately after you arrived. What I'd like to do today is go into a couple of the areas that the medical school impacts and how they impact them still today. The first area is recruiting of faculty, particularly the chairs and new chairs of departments. When the faculty were originally recruited there was a strong emphasis on developmental skills of the chairs involved and the faculty members. Is that emphasis still there today, or is there a different type of emphasis that you want put on specific types of faculty you want to recruit?</p>
WS	<p>When one starts a new institution, as you point out, you're interested in people who- you have several responsibilities. When your doors open for people you have to have people to teach those classes, so first and foremost, one recruits people to come and meet those mandatory teaching needs. You simply have to have them. And obviously, in the initial phase of a new school when it's unknown, that recruitment is difficult. You're looking for people who are adventurous, who might be given the opportunity to be a chair or be a leader earlier than they would in the traditional university. You take some chances, people that maybe ten years later you might have not recruited for a position, because you have the necessity to have your program go. I think that people who come here, as we discussed when we were talking about why I came here, had to have a sense of development [and] wanting to play a leadership role at an early phase of their career and try to build something. As the institution begins to have an identity, to find foci of excellence or quality, to sort of work together for a while, I think it then becomes possible to look at recruiting in a different way. One's got the essential ingredients of teaching classes taken care of and you begin to look at the overall institution in terms of its development. Let's put a hunk of resources here and develop this program because we've got a sound nucleus to build from and this is an opportunity to pursue genuine quality or excellence in this arena, and then as resources are built up again then you pick another area, and certainly the normal academic turnover creates opportunities to do that. For example, in physiology, we</p>

	<p>just reached agreement last week with Dr. Peter Lauf to come chair the Department of Physiology. Dr. Kolmen, who was the original chair, was very interested in development and putting together academic programs in the administrative side. Now with Dr. Kolmen's departure, the recruitment of a new chair gave us the position not only to look at someone who would be administratively sound, but of a whole host of other academic interests, and Dr. Lauf who is coming here after a distinguished career in the Physiology Department at Duke where he is full professor, he's going to be bringing in some whole new insights to the institution in the area of biophysics, cellular and molecular physiology, will bring in a considerable interest on scholarly creativity, which is a part of our mission. So those kinds of turnovers do occur and the emphasis changes. I think again if you go back and look at the Department of Medicine [<i>Physiology</i>] it's now on its third chair, and we've made a progression in styles of the chair of physiology, I mean of medicine, I'm sorry [<i>this was misspoken; he is referring to physiology dept.</i>], to someone now whose both a superior teacher, sound administrator, and academically a very sound leader and is known for his achievement around the country. Those are natural progressions, and I think I could probably go through several departments with the same litany. So, I think, yes, as the institution evolves you, one, look for people with some different skills or different strengths while still maintaining a balance, and two, you are better able to recruit in that you aren't solely looking for- your pool isn't restricted to pioneers.</p>
JSJ	What's the general term of service for a departmental chair at a medical school?
WS	<p>We, like many, many of the medical schools in the country, do not have a fixed term of service. Our appointment process is such that we make a recommendation if we want a fixed term of service to the executive committee and they'll approve it, but all of ours are appointed as administrative appointments to the chair, and we have nobody appointed with a fixed term of service. The professorial appointment, of course, is subject to review by the continuance procedure of the School of Medicine, but the administrative appointment is at the pleasure of the university. We have in our by-laws a mandated review of the administrative role of the chair at intervals not to exceed seven years, and we have been conducting those regularly. A goodly number of our chairs have been reviewed, it has been a very good and positive process, not a witch hunt or a destructive one, and we follow the procedures mandated by our by-laws.</p>
JSJ	Do all chairs serve at the pleasure of the dean?
WS	<p>I don't make the appointment, but I recommend the appointment to the provost and the president, so I'd say it's at the pleasure of the university. But fundamentally, if a dean says a chair has got to go, then either the dean or the chair is gonna go [<i>laughs</i>], and you can't depend on which of those it's going to be, and this is characteristic of most university medical schools, I think.</p>

JSJ	Let's move into the area of the several organizations that merged with the medical school early on in its history. There were four basic organizations: The Bob Hipple Lab, The Cox Heart, The FELS Lab, and there was the association between the university and the Drew Health Center. Where do those areas stand now?
WS	<p>The Drew Health Center and association I'm going to tell you I know virtually nothing about, and people who were here at the time when that developed and then in essence became a dissociation of any active role are going to have to tell you about that, Jim. I simply don't have anything other than hearsay and that's not worthy of recording. Okay, let's start with the FELS. The FELS was an independent research organization- supported by the FELS Fund and grants- in Yellow Springs with a long and distinguished history of outstanding scientific contributions, a substantial physical plant, and they became a part of the university shortly before a time where some interesting changes in American medical research support occurred. During the early days of the institute, there was substantial ongoing support by the FELS Fund to the university as a part of the agreement to incorporate the two. That had a five year limit to it. At the end of that five years, the FELS Fund in effect indicated their desire to disassociate themselves from funding it. Their obligation was met fully and without compromise, but they then said, 'We would like to as a foundation or fund devote more of our resources and attention to the local Philadelphia area', and in effect disengaged from any ongoing support to the FELS Institute. At that time, they did make a small continuing grant for specific, programmatic support for two years, but then did not continue after that two years. We were faced also, at the same time, with a decline in the extent of federal support for research in terms of the ease of getting grants, the proportion of grants that were funded, and with retirement of some of the senior FELS investigators, and so with the departure of their participation and support, it became important to us to have a comprehensive look at the FELS Institute. We did- a number of studies were done, small groups, ad hoc committees, people were given assignments to look into other activities that could be placed in the FELS, and with the passage of time, it became clear increasingly around the country as well as here I think, that independent institute combinations with researchers in a university setting was not quite so popular as it had been in the '60s and '70s, and in fact were having problems. Because this was a group of people who if they didn't get their grants, became a load on the institution, but they were not in the institution in a full teaching and participatory sense, and we, like others, were concerned about this. We did a fairly comprehensive study of space available, etc., location, ease of other utilization, and reached the conclusion two years ago that the cost of maintaining the FELS Institute, the overhead for keeping the building operational at that location, was far in excess of the indirect cost that came into the university as a result of grants, and that we were paying a heavy price in dollars to maintain the buildings and that there were very limited academic, scientific uses for the medical school in that building in Yellow Springs. So at that time we devised a plan of relocating the FELS investigators who were then active. That appeared to be pleasing and satisfactory to them. That accommodated them well or adequately in other existing</p>

	<p>school of medicine space, and [we] proceeded with that plan. So the FELS investigators continued to carry that title, the FELS Institute as a concept is as alive as it was, we simply have moved out of the FELS house, a building, and that has reverted to the university generally for such uses they make of it, I think it's basically being moved into a mothballed situation right now.</p>
JSJ	Where are the FELS researchers working right now?
WS	<p>One set is working at the so-called Yellow Springs Clinic building that is just up the street, a half block from the FELS Institute. That building where one of our residency programs, Family Practice Center, is located. It was not fully utilized and there was some undeveloped space in the basement level, and that has been re-done and brought up to standard, and the Psychology section and the Growth and Development section are located there, and Dr. Varandani's group of biochemists have moved on to the campus in space that was developed for them specifically here where they could be in juxtaposition with the rest of the biochemists rather than in an isolated location.</p>
JSJ	Is there any central coordination of FELS research programming?
WS	<p>Now it is done through our departmental structure, to the extent that we track- the FELS investigators, when they came into the School of Medicine, all have appointments in one of our ordinary departments or regular departments. The Growth and Genetics, or Development and Growth people are part of the Department of Pediatrics, Psychology is part of the Department of Psychiatry, and Dr. Varandani's group are in the Department of Biochemistry. So that operation is done through our regular structure, and as a matter of fact, even during the height of the FELS Institute they in essence functioned as independent investigators, each with their own segment of activity within a FELS structure, so I think that really very little has changed except they're not in the FELS house now.</p>
JSJ	Do they teach?
WS	Yes.
JSJ	What kind of teaching requirements do they have? Do they have a minimum requirement?
WS	<p>We try not to- we've never set for our full time faculty any statement of each individual must teach X number of hours. We look to our departments to maintain their instructional program and a balance of activity for all of their faculty. Dr. Cogan[?] in Pediatrics tends to set down fairly firm job description agreements that says I expect 10% teaching, 15% service, and what do we got left, 75% for research or so forth. All of the FELS people were on board as researchers, they were in a research institute, and I think their jobs for the most part are heavily research oriented, and that's understandable and perfectly reasonable. Br.</p>

	<p>Varandani, for example, has graduate students, post-doctoral fellows, he also teaches medical students in biochemistry. The group in Growth and Development have post-doctoral fellows, they work with residents in Pediatrics, they make presentations to the Pediatrics section, they help out in a number of areas, working right now with our curriculum committee as part of our task force looking at how we are to introduce computers in medicine, and if that program comes in I would guess that one or two of them that have a particular interest in data retrieval, processing etc., could play a key role in what I hope will soon be a program in the role of computers in medicine for our undergraduates. So it's going to vary from individual to individual.</p>
JSJ	<p>What about the Bob Hipple Lab?</p>
WS	<p>Yeah, the Hipple Lab was- again, I don't know what you've got historically, and since its arrival antedated me I'll just give a brief synopsis- was organized by Mr. Hipple and his family to support Dr. Murphy when Dr. Murphy was at Sloan Kettering and through a variety of connections which I've never been totally clear on who contacted whom about what at which time. The approach was made that Dr. Murphy was going to be leaving Sloan Kettering and the prospect of him coming to Dayton to set up his lab because of the Hipple family and foundation connection with Dayton and it was worked out that that would be done together with the School of Medicine, and space was developed for him and some equipment was provided etc. by the school, to be located in the Cox Heart Institute Building on the grounds of Kettering Medical Center. Dr. Murphy came and began a fairly rigorous program of building on the Hipple Foundation's help initially and community based fundraising, and the Bob Hipple Laboratory developed. They have decided now- he and the key advisors of his- that they would like to become an independent entity of the university, and as of March 1 will become independent of the university. A development/growth spinoff kind of pattern, if you will. It's an amicable parting, they will be moving out of the Cox Building and the space will be utilized for other academic programs. So that separation will occur in the next week.</p>
JSJ	<p>What about the Cox Heart?</p>
WS	<p>The Cox Heart Institute- again, the joining preceded me- goes back a fairly long time in Dayton, a goodly number of years. It originally began as an idea of Doug Talbott that computers and automation and data processing were going to be key to clinical care, as I understand it, and was really one of the first places in the country, and maybe the world, to try to utilize modern technology- the then developing computer, data recording, electronic display of information, monitoring- for the care of cardiac patients, and developed with gifts from the Cox family and others on the grounds of Kettering Medical Center as an independent research institute with those rather specific objectives in mind. It was set up in essence as one of the early cardiac care units, with monitoring, telemetry, use of computers, etc., and they also got into a fair amount of basic and applied research</p>

	<p>in heart disease. Dr. Kezdi was an early member of the institute and when Dr. Talbott left, I believe Paul Kezdi became the director of the Cox Heart Institute. Over the years, the institute had not been established with an endowment. It had been established with annual gifts of money plus grant and service earnings, and as the Cox family's interests and enterprises became removed from Dayton, the interest in that becoming a part of the newly formed school as a clinical research center for the school and the interest of the institute came together, with the transfer of ownership of the building to the school on a very long term lease arrangement with the land remaining the property of the Kettering Medical Center on a long term lease. We're now nine years into that, and the building is a very valuable resource in terms of a site for clinical research closely approximate to a hospital. With time, the grant support for the Cox Heart Institute has declined, and the number of active researchers in Cox has declined. The School of Medicine's contributions have been significant and steady, and with Dr. Kezdi's pending retirement as director at the age of 70- although I anticipate he will continue as a faculty member according to the university's provisions for that- we are going to be looking very carefully at the Cox Heart Institute piece, and really view it now as a setting for clinical research, as an entity, rather than specifically a heart institute. What we do with the 'heart' portion will depend very much on some looks into fundraising, recruiting and so forth over the next year or a period of time. Currently, activities there are quite diverse. The Hipple Lab is there but will be moving. We have programs there, clinical research involving emergency medicine, cardiac surgery, plastic surgery, we're putting our laboratory for magnetic resonance, a portion of that program will be in the Cox Building, we're looking forward to a program involving pediatrics, a program of the Heart Institute that Dr. Kezdi and his colleagues is continuing. The institute is also providing space for the Dayton Clinical Oncology Program, which is a federally and locally supported program of experimental oncology involving the community hospitals and the school, and so forth. We anticipate that the research institute or the clinical research center concept will remain with multiple users at Cox at the building.</p>
JSJ	How does the clinical research aspect of Cox affect medical students?
WS	<p>In several ways, and let me speak about our research enterprise totally, because it's probably the principle way in which it affects medical students. I am convinced, though I guess I'd hate to have to try to prove it to you unequivocally, that education thrives best or is best served where there is also an active spirit of inquiry and creative scholarship, and to attract the kind of faculty, the kind of people, residents, others, and to create the overall environment of inquiry, innovation, of excellence, of the pursuit of excellence, of quality that we want our students to participate in and become a part of requires an active program of investigation. So an active, creative scholarly program- whether it's at Cox, whether it's in a basic science laboratory, or whether it's at our research facilities at the VA or at Children's, wherever, FELS- is an integral part of our education program and I think it is critical for it to be a quality one. So that's one, broad generic way. Secondly, we have a significant number of students who during their</p>

	<p>medical school careers spend time working with one or another of our faculty in their research laboratories or in their clinical research setting engaged in research, and we think that's an important experience for those students. It's not all, by any means, but it is a significant number and we encourage that. They may or may not decide that research or academic medicine is for them, but that problem solving approach to things is increasingly becoming a necessity for our educational program. Thirdly, residents and post-doctoral fellows, and faculty need the opportunities for them to remain- first to attract them for them to remain current and active and stimulated. And it's fun, and then it's a responsibility to create new knowledge.</p>
JSJ	<p>What impact does the research facilities have on specific- like your one post-graduate medicine program, the Biomedical PhD program, does that use those research facilities also?</p>
WS	<p>Yes, although, like any PhD program, it is more focused into the sciences basic to medicine than it is in clinical activities. However, Dr. Varandani has had graduate students. We have a variety of kinds of opportunities for graduate students to work together with people who are engaged in clinical research, although the PhD students tend to concentrate in the more conventional, basic science areas.</p>
JSJ	<p>As well as an opportunity to research, most medical schools offer their faculty and staff an opportunity to practice. One of the things that was developed with the medical school was the University Medical Services Association. Can you tell me what- is that a normal type of association created for a medical school? What was it like when you came here, and how has it developed since you've been here?</p>
WS	<p>Okay. An overwhelming majority of medical schools, but not all, have some kind of practice plan for their faculty, and this has evolved really since World War II, particularly in the '60s. Ours is not atypical, there are about as many variants on the fundamental theme as there are medical schools that have them. But the idea behind it is a simple one, that in order to teach clinical medicine, the faculty, one, have to be engaged in clinical medicine and they have to have patients for which the teaching can occur, and they must maintain their skills, and to do that requires an opportunity to practice. That opportunity to practice means they are delivering service for which they can and should be reimbursed, in the reimbursement scheme. So, furthermore, in Ohio at the time the school was started there was a maximum salary for state employees that was well below a typical salary for a clinical faculty member, and indeed without the opportunity to supplement the income, it would have been impossible to obtain or retain competent clinical faculty. So a practice plan afforded them the opportunity to benefit in an incentive way for their practice activities so that they could be hired. So a practice plan is a benefit to the school in that it maintains competence, it's a clinical outlet to maintain competence, gain patients for teaching, and to enable us to attract and be competitive for first rate clinical faculty and teachers. The system at Wright State is one that was put in given all the considerations of Ohio Revised Code and</p>

	<p>various things at the time for a private, for profit corporation outside the university. The one link to the university is that the dean of the medical school must be involved in the practice plan. It was really in its early days when I came and has evolved significantly since. I believe that there is general faculty satisfaction with the practice plan. Sure, “X” would like to have it work slightly differently than “Y”, but some unrest that existed early on I think has been put to rest. We have an outstanding young man who serves as the executive director, Donald Jansen, he’s done a great job, the plan is financially sound, it is benefitting the School of Medicine very significantly in terms of a proportion of the practice income is supporting school activities, it supports the activities of departments for their development, and it makes feasible the recruitment of high quality clinical faculty to the school. The plan has been very carefully structured so that it is not permitting or taking advantage of the university, that is the plan doesn’t get free space or free services, it pays for what it uses, just like any other agreement. As dean I am a shareholder in the plan, as dean I am chairman of the board of directors, and as dean I chair the management committee or the equivalent of the executive committee of the plan. All of our fully paid faculty are eligible to be members of the plan, that includes MDs, PhDs, or what other “Ds” we have in the school, and all- there may be one or two for whatever reason choose not to, but in our strict full-time contract the university precludes income from professional activities that is apart from their participation in the University Medical Services. I think it has been a very good operation for all parties. Clearly the school benefits, clearly the departments benefit, and clearly it makes it possible for our faculty to be competitively compensated.</p>
JSJ	Is there still that ceiling on official salaries? I think it was \$55,000.
WS	No, that was removed.
JSJ	When was that removed?
WS	What, three years ago now. I think it was three. It could have been- over a period, this is my fifth year and all of a sudden which year and what happened when sort of gets merged. I think it was three years ago. This budget year will be the fourth year without the ceiling.
JSJ	You said that the UMSA provides some of the funding for services within the university, servicing some of the departments within the School of Medicine. How does that- what proportion of the budget does that include, and let’s go from there into a look at the financial status of the school. Where does your revenue come from basically now, now that you’re not financially dependent on the VA grant?
WS	Okay, several sources. One is the various state subsidies that are provided through the Board of Regents, and those fall into a few fairly simple categories. There’s the instructional subsidy, the so-called Medical Model II, from the Board of Regents and the State of Ohio. Then there are some special subsidies, there’s one

	<p>called the Clinical Teaching Subsidy. There is another called the Family Practice Subsidy, which was a special law passed by the legislature to provide funds for the development and expansion of family practice programs. There's a primary care subsidy which follows the same pattern, it's focused on primary care generally, and there's a gerontology, or geriatrics subsidy, which again was a law passed by the legislature appropriating funds to support developments in geriatrics. By and large, that's the state piece.</p>
JSJ	<p>Are those subsidies on a per capita basis?</p>
WS	<p>Some are per capita. Medical Model II is strictly a per capita phenomenon. It's the headcount of undergraduate medical students. The others are based on formulae or decisions, either legislative language or formulae that are worked out among the deans and the Board of Regents that contain various kinds of calculations to arrive at the allocation of funds equitably within the state system. It becomes very difficult to say there is "a" formula. Geriatrics is done one way, Primary Care is done another, and Family Practice is done a third way. But they are all formula driven, as it were.</p>
JSJ	<p>Are they specific, limited term agreements that are subject to renewal by the legislature?</p>
WS	<p>Like all state funding, it's always subject to renewal with each budget process by the legislature.</p>
JSJ	<p>So it's biennial in nature?</p>
WS	<p>Yes. It's a part of the state's budget process. Then there is, in addition, money that comes from- that includes state funds and federal funds under the Area Health Education Program, the so-called AHEC program, which began as a federal grant to a consortium of all of the medical schools in Ohio, and there is state support for AHEC and federal support for AHEC. We are rapidly approaching the phase-out of the federal support for AHEC, and the state support has been increasing. So that's the bulk of the state funding in those various categories. Another big segment, of course, is tuition and fees. Another big segment is what I'm going to call clinical service agreements. In our operating philosophy in a community based school, people involved in rendering service in a community hospital, our faculty who do that continue to be paid by the school. But the hospital reimburses us in an agreement that's negotiated, it's a two-party agreement, and that is used as income by the school to contribute to our general operating expenses. For example, if one of our faculty serves as an instructor in a residency program in a hospital, or supervises a clinic, or administers the infection control committee, etc. That is a service provided by the school to a community hospital, and that's done under an agreement by which we provide that service, and it's reimbursable service. So that provides a significant part of our operating costs. The remainder is in a whole host of categories. There are grants and contracts that carry both direct</p>

	and indirect support. There are obligatory contractual commitments from the University Medical Services Association to the School of Medicine as a part of our agreement with that organization. We have some miscellaneous income when you sell something that's a piece of surplus property. I've run out now of- and then we have gifts, we have foundation income-
JSJ	How much of that is endowment?
WS	Endowment, Jim, I'd have to go back and get out the figures, let me do a quickie. We currently have something in excess of two million dollars in funds that I would use the term "endowment" for, and that body of endowed funds has been increasing progressively, and we have not been dipping into the principal at all for operations, and in fact have been accumulating the earnings from that for our overall fiscal situation. And we're actively pursuing a number of other fairly significant gifts, currently.
JSJ	Do you still have a separate development office for the School of Medicine?
WS	No.
JSJ	You work then through the university's development office?
WS	Yes, we work with the Wright State University Foundation and Mr. Czarnecki and Mr. Edwards.
JSJ	Do you have separate contingency funds for financial exigency that you've set up after the last budget crunch?
WS	With a slight correction- I would say not after but as a part of, yes. Separate just as the university has- if you will- reserve funds, we do and those have increased significantly over the past four years.
JSJ	How would you look at our medical school's tuition and fees as opposed to other medical schools, both in the state and nationally?
WS	We're just about at the middle. With seven schools [in the state], I think we're number three from the top, and nationally we're about at the middle to a little above the middle of the state schools. We're- the system we put into being about three years ago whereas to look at the way Medical Model II is funded in Ohio, in Medical Model II comes out with a number that says this is what the state calculates should be put into the school for each medical student per year, and then they do a deduct from that of a sum. Now, in Ohio- and I think it's very valuable that this right remains- the Board of Regents or the legislature don't set our tuition. Each university sets its tuition, and we are part of that process with our Board of Trustees in the medical school tuition. But if you will, that deduct is a kind of number that says 'we don't care how you do it, but we're going to deduct this

	<p>amount of money because you might earn that from tuition and other resources'. And that number is right around the mid 5000 dollars, 5500, somewhere in there, in Med Model II. We pegged our tuition three years ago at that deduct number; the annual fee was what that was for that year, and we in essence told the students why we were doing it, how we were doing it, the rationale for the number that was picked, and we said that we would try to hold the tuition at that level. We tried to take into account that deduct and what was the projected cost of education, and we haven't raised the tuition in the subsequent two years, and no current plans to recommend an increase for next year.</p>
JSJ	<p>Let's go from the general budget to a specific area. I'd like to trace the history, if we can, of the Frederick White Ambulatory Care Center. When that building was established, was it established on the basis of a certain use-philosophy or mission statement, and has that changed?</p>
WS	<p>Let me give the qualifier, that was all done and the planning and execution of that was all done prior to my time or independently of the medical school. There was an idea that was not unique to Wright State, it was a very powerful movement in the country towards ambulatory care centers in the '70's, that these were going to become the site of health care delivery, that they were going to be comprehensive and innovative, and that there would be funding for them just like there was for hospitals and so forth. A plan was developed [unintelligible] projecting use, there was an interest in a hospital in Fairborn, and the idea of an ambulatory care center grew in cooperate rather than a Fairborn hospital emerged. A lot of factors came together to plan a center for ambulatory care, and state money was obtained and the center was built and designed. A number of things occurred: a) the kind of funding models that were believed the feds and others were going to put into play never came into play. The breeze didn't go that way, etc., and it turns out a freestanding ambulatory care center has got to make it on its own. Very difficult to do if you don't have a hospital. Ambulatory care centers like that tend to be dependent on when a patient leaves there going into a hospital that there's some interchange of those revenues in one way or another. And patient projections were on target in the early years, but the growth in patient volume etc., did not achieve- is not going to achieve over the long haul the initial projections, the service area is not as big as it thought it might be, we've had Huber Heights Health Center come in, we see St. Elizabeth's just down the street, we've seen other activities, the HMO came out into Fairborn. A lot of factors, a changing climate of health care delivery has occurred so that the full clinical development of the ambulatory care center simply did not occur as it was projected, and above all the payment of costs did not come through as it might have been hoped for. Two years ago- or a year and a half ago I guess now, almost two years ago- I was asked to create a study of the Center for Ambulatory Care, where its projection was out in the future, alternative uses and the like. I put together a study team of staff [and] the director, Don Jansen, of the center, and we spent- we used some consultant time, we did a very careful, new analysis of patient populations, projected buy-ins not based on the old assumptions but we wiped out all the assumptions, we said let's look at in</p>

the mid-1980's, with Huber Heights, with all of these other things occurring. We met with a variety of people throughout the university about their interests and potential uses for the building, considered a variety of models to maintain the Center for Ambulatory Care and in ensuing presentations to the board developed that study, and last year at the conclusion of the study we recommended to the board that the Center for Ambulatory Care as an auxiliary enterprise be disbanded, for a whole host of fiscal, use... the climate had changed and that we did not see that as being the way to continue as an auxiliary enterprise with the notion that it had to zero out in the university budget system. That wasn't going to happen. That there are inherent costs in making it a teaching center, there are limitations to its teaching etc., and that other uses ought to be made for the center, but clinical activities ought to continue there but not as an auxiliary enterprise that had to zero out in the budget. The board accepted that and agreed that Dr. Ferrari and I should develop a use plan for the center for alternative uses, and Dr. Ferrari asked me to utilize the same planning group to make some proposals and suggestions, which we did, and considering all the things involved a final decision was made that in effect the School of Medicine would become the primary occupant of the building and have the primary responsibility for it. The counseling center would remain there as a part of the activities of Professional Psychology, and I think we have the ROTC store room and issue room down there, and that there might be some room for some separate enterprises, but instead of as an auxiliary enterprise, it's a part of the School of Medicine and others who utilize the building pay the- the university in some way puts their dollars into it, just as we put in the dollars for the space we utilize. We then did several things, we as a continuum did a fairly comprehensive examination of all of the space that was available, not only for the White building, but in the Medical Sciences and Bio Sciences Buildings in relation to our school needs, and developed a proposal for an integrated and fairly extensive modification of the White building, Bio Sci, Med Sci that put together a big package of multiple little packages, presented that to the board, to the Building and Grounds Committee, up through the channels and got board approval for that, and we're now very much into the implementation. What we're going to do down at the Frederick A. White Building is to develop what was a clinical laboratory and a large warehouse into full-fledged academic space. We will be moving probably one entire department down there for that space for research, offices, we are going to build some additional teaching facilities. The Fred A. White Building is short on classrooms and conference rooms, because it was originally planned that the multiple sclerosis center would complement it, and there would be more classroom space in the MS center. That plan, of course, is on indefinite suspension right now, so we're going to build some more conference and teaching space, we're planning on putting three departments in total down there that are not there, and Medicine and Society is going to move, we're going to locate Dermatology there, we're going to revise some of the teaching activities. We've in the meantime started a Medicine Pediatric Residency Program with support from a major federal grant, located there, and we're increasing our teaching, medical student teaching activities there. There will be other modifications as a part of this whole plan to utilize the space that people are moving out of and to develop some

	<p>additional space that became available according to plan after the Health Sciences Building came online, and that will in part be accommodating the new folks in Physiology and some expansion of existing programs. So that's underway right now. We continue to have a fairly brisk clinical operation in the Fred A. White Building under the auspices of the school-</p>
JSJ	<p>What type of clinical operation?</p>
WS	<p>We've continued the Family Practice Program, we've continued the Medical Specialties Clinic and expanded some of those, Dermatology is expanding, Radiological Sciences. We have [the] Psychiatry Residencies Program, a center for them to see chronic, ongoing patients. Aerospace Medicine is doing research as well as clinical care down there. We've begun, fairly recently, a Clinical Pharmacology Program in which we can do drug testing in volunteers on a 24, 48, 72 hour basis in the center on a contractual basis with drug firms. So a host of kinds of things are going on there and we're seeing some modest growth in patient volume as we add new activities like the Medicine Pediatrics Program, and we believe that the operation is looking a little better fiscally this year than it did last. But more importantly, the amount of money that we're putting in from the School of Medicine's Clinical Teaching Subsidy into the building is now going to be better justified because there's increased teaching going on and there's increased utilization of the space, so if you will, the amount of money that's had to be put in to maintain the building, and it's a high cost building, is no longer dependent upon clinical revenues to balance it out. We've got other functions in there that justify that commitment of funds.</p>
JSJ	<p>Well, thank you very much for this interview, it's been an excellent interview, and in the next one I'd like to cover a couple of areas that we haven't had time to cover today, like the growth of the voluntary clinical faculty, and your relationship and the school's relationship with area medical societies and hospitals, and then let's move into what you perceive as to be the immediate and not so immediate future of the medical school and its areas.</p>
WS	<p>Okay.</p>
	<p>END</p>